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# Child abuse

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CSA;
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**Summary**
Child abuse is a wide-ranging concept that can be defined as 'anything that hinders the optimal development of the child'. This includes physical abuse (non-accidental injury (NAI)), emotional abuse and deprivation, and child sexual abuse (CSA). It also includes abuse by agencies other than parents, e.g., professionals, systems and politicians. Child abuse work is a challenging and vitally important area of responsibility for all paediatricians. There have been several recent high-profile cases where the careers and reputations of senior paediatricians have been threatened because of their involvement in child protection work. These cases show the need for much greater professional protection for paediatricians in their continued commitment to child protection work. Despite these high-profile cases, it should be stressed that child protection work can provide the paediatrician with some of the most dramatic opportunities to help change children's lives for the better.
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## Introduction

Child abuse and neglect in all its forms is probably the major public health challenge affecting children in the UK today. In his report on the death of Victoria Climbié, Lord Laming said

> I have no difficulty in accepting the proposition that this problem (deliberate harm to children) is greater than that of what are generally recognised as common health problems in children, such as diabetes or asthma.[1]

## History of child protection 1961–2005

Historically, paediatricians have often been pioneers in child protection work, both in describing different forms of abuse, in policy formation and education of the public. It was an American paediatrician Henry Kempe, in 1961 who first drew attention to child abuse by his description of the 'Battered Baby Syndrome'. In the UK, the names of Alfred White Franklin, Dermod McCarthy, Christine Cooper, Jane Wynne, Chris Hobbs, Marieta Higgs, Geoffrey Wyatt, Sir Roy Meadow, Camille Lazaro and David Southall all deserve honourable mention for their pioneering work. While society treated the earlier three paediatricians with the utmost respect, it is a matter of regret that all the others have suffered threats to their careers and reputations to varying degrees as a direct result of their work in child protection. The nature of the different controversies involving the above is beyond the scope of this article. However, the political reality is that the most recent high-profile cases must weight heavily on the minds of all paediatricians. The temptation to 'opt-out' of child protection work is strong, although difficult to carry out in practice. Furthermore, equally worrying is the fact that younger doctors may be

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less likely to choose paediatrics as a career. Clearly, paediatricians are going to require much more support and protection from society (including the media, judiciary, the General Medical Council (GMC) and from their own College) if they are to continue to carry out their duties to protect children.

Although the examples of the high-profile cases have all involved paediatricians being penalised for their positive diagnoses of other forms of child abuse (sexual abuse, Munchausen Syndrome by Proxy, smothering), it is worth stressing that the main way in which front-line secondary care paediatricians have suffered professionally is from their failure to make a positive enough diagnosis of non-accidental injury (NAI) leading to the death of the child. The tragic case of Victoria Climbé is just the latest example of this phenomenon. It is impossible in one article to do justice to the complex issues surrounding emotional abuse, emotional deprivation and neglect, and sexual abuse, despite their very real importance as public health problems and the fact that the paediatrician's role in these areas can often be crucial.

This article will therefore focus on the diagnosis and early management of NAI, as this is the commonest problem that a newly appointed consultant can be expected to face.

## The diagnosis and management of NAI

The differential diagnosis between NAI and innocent accidents can be one of the most intellectually and emotionally challenging diagnoses a paediatrician is required to make. The consequences of 'getting it wrong' either way are potentially so catastrophic that every effort should be made to get as near as possible to 100% in terms of diagnostic accuracy. Accordingly, adequate time should be set aside for the task. Do not let yourself be forced into a snap decision on a Friday afternoon, without having time or opportunity to gather all the evidence. The paediatrician should approach each case with an open mind, and proceed with infinite care and thoroughness. He/she should avoid leaping to conclusions, while recognising that ultimately a firm conclusion will have to be made. One of the biggest difficulties is that in every other area of practice the paediatrician is used to believing what the parents say. In contrast, some degree of dishonesty is only to be expected of the parent in a case of NAI. Another common area of confusion is that the behaviour of an abusive parent can be identical to that of an innocent parent who feels wrongly accused, and for instance runs out of the hospital with the child in a panic.

## Standard of evidence required

Probably the most important area for error results from a failure to appreciate the level of proof that is being asked for. Although one is striving for 100% accuracy, this is not the same as requiring 'proof beyond all reasonable doubt'. This is the standard of proof required for a successful criminal prosecution, which is not the prime concern of the paediatrician and social services. Their prime concern is the safety and well being of the child, and this is a matter for the Civil Courts, where the standard of proof required is 'the balance of probability'.

Accordingly, paediatricians should accept that eventually a decision has to be made whether the diagnosis is NAI or an innocent accident 'on the balance of probability'. This will prevent the paediatrician saying 'I cannot say for certain' in a probable case of NAI and leaving Social Services (SSD) unable to protect the child.

## Possible results of failure to diagnose NAI

- the child may suffer from brain damage and severe handicap,
- the child may subsequently be killed,
- the parent may be jailed for murder/manslaughter/GBH,
- the opportunity may be lost to save the child from a childhood of chronic emotional abuse and deprivation,
- the paediatrician may be sacked or suspended, and/or referred to the GMC.

NAI is not a final diagnosis: it is a symptom of a disordered family. The degree of danger to the child is not necessarily proportional to the severity of the initial injury; it is proportioned to the severity of the underlying family disorder (which should be assessed separately). Thus, even a medically severe injury (skull fracture, fractured femur) need not be an absolute barrier to subsequent rehabilitation, while 'minor' finger-tip bruising to the cheeks of a small baby may warn of a risk of subsequent death or brain damage.

### Case illustration A

A post-graduate student from abroad was under great stress while attempting to complete his research with two small daughters continually crying and disturbing his study, while his wife was semi-depressed. In a crisis he threw both girls against a wall, fracturing their skulls and causing extra dural haematomas. He received a custodial sentence but social work assessment was favourable and 2 years later the family were successfully reunited, the girls having made full recoveries.

### Case illustration B

A 1-year-old girl was referred from Accident and Emergency with fingertip bruising to the face. The family were known to SSD because of a previous episode of NAI, the 1-year old having been returned to the family 3-weeks previously. The assessment of the family showed such dangerous features that the child was removed and placed for adoption.

In the older child, the risk may be less yet the occurrence of medically 'minor' injuries (cigarette burns, facial bruising) may themselves be strong markers for chronic emotional abuse. Physical abuse of older children should not be dismissed as 'over-chastisement'. Paediatricians should include these aspects in their reports and stress their importance, as the mere avoidance of death is a very lowly ambition in child protection work.

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